Department of Health and Human Services
MENTAL HEALTH SERVICE BUREAU

STATE OF MONTANA
Department of Public Health and Human Services

HOME AND COMMUNITY BASED SERVICES DISCHARGE SHEET

Individual's Name: _____ _____
(Last) **(First)**

Individual's Medicaid Id#: _____ **Case Management Team No.:** _____

Most Recent Admit Date: _____ **Discharge Date:** _____

DISCHARGE CODE: (Circle One)

1	**Death**	**8**	**Voluntary Disenrollment**
2	**Nursing Home Placement**	**9**	**Other (Specify)** _____
3	**Hospital Placement**		_____
4	**No Longer Requires Services**	**10**	**No Longer Meets Level of Care**
5	**Medicaid Ineligibility**	**11**	**Care Category Change ***
6	**Moved From Service Area**	**12**	
7	**Exceeded Cost Limit**	**13**	**Year-End Money Completed**
		15	**Psychiatric Placement**

*** Submit a new Intake Sheet with updated information.**

Signature: _____ **Date:** _____

SDMI HCBS 899-13

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